Filing at a Glance

Company:	American Medical Security Life Insurance Company
Product Name:	AR AMSLIC
State:	Arkansas
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	09/21/2012
SERFF Tr Num:	AMMS-128697244
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	41765-A
Implementation Date Requested:	On Approval
Author(s):	Jean Davis, Jennifer Konschake, Debra Schneider, Luke Peters
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	09/26/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *American Medical Security Life Insurance Company*

TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *AR AMSLIC*
Project Name/Number: *AR Notice of Appeal Rights/41765-A*

General Information

Project Name: AR Notice of Appeal Rights
Project Number: 41765-A
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission

Overall Rate Impact:

Deemer Date:
Submitted By: Debra Schneider

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual, Non Employer Group - Individual
Filing Status Changed: 09/26/2012
State Status Changed: 09/26/2012
Created By: Debra Schneider
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:
Request for Approval
41059-A, Notice of Appeal Rights (Non-Grandfathered Plans)
41765-A, Notice of Appeal Rights (Grandfathered Plans)

Submitted for review and approval is American Medical Security's Notice of Appeal Rights for Non-Grandfathered Plans (41059-A) and Notice of Appeal Rights for Grandfathered Plans (41765-A).

To the best of my knowledge, this filing complies with the statutory and regulatory requirements of the state of Arkansas.

If there are questions or additional information is needed, please contact me at (800) 232-5432, extension 12286. My fax number is (920) 661-9861, and my email address is dschneider@goldenrule.com.

Thank you for your time and attention to this filing.

Company and Contact

Filing Contact Information

Debra Schneider, Senior Contract Analyst
3100 AMS Blvd.
Green Bay, WI 54313

dschneider@goldenrule.com
800-232-5432 [Phone] 12286 [Ext]
920-661-6554 [FAX]

Filing Company Information

American Medical Security Life Insurance Company
3100 AMS Blvd
PO Box 19032
Green Bay, WI 54307-9032
(800) 232-5432 ext. [Phone]

CoCode: 97179
Group Code: 707
Group Name:
FEIN Number: 86-0207231

State of Domicile: Wisconsin
Company Type:
State ID Number:

SERFF Tracking #: *AMMS-128697244* ***State Tracking #:*** ***Company Tracking #:*** *41765-A*

State: *Arkansas* ***Filing Company:*** *American Medical Security Life Insurance Company*

TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *AR AMSLIC*
Project Name/Number: *AR Notice of Appeal Rights/41765-A*

Filing Fees

Fee Required? Yes
Fee Amount: $100.00
Retaliatory? No
Fee Explanation: $50 per form x 2 forms = $100
Per Company: No

Company	Amount	Date Processed	Transaction #
American Medical Security Life Insurance Company	$100.00	09/21/2012	62944360

SERFF Tracking #:	*AMMS-128697244*	***State Tracking #:***		***Company Tracking #:***	*41765-A*

State:	*Arkansas*	***Filing Company:***	*American Medical Security Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*AR AMSLIC*		
Project Name/Number:	*AR Notice of Appeal Rights/41765-A*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/26/2012	09/26/2012

SERFF Tracking #:	*AMMS-128697244*	***State Tracking #:***		***Company Tracking #:***	*41765-A*

State:	*Arkansas*	***Filing Company:***	*American Medical Security Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*AR AMSLIC*		
Project Name/Number:	*AR Notice of Appeal Rights/41765-A*		

Disposition

Disposition Date: 09/26/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Notice of Appeal Rights (Non-Grandfathered Plans)	Approved-Closed	Yes
Form	Notice of Appeal Rights (Grandfathered Plans)	Approved-Closed	Yes

SERFF Tracking #:	*AMMS-128697244*	***State Tracking #:***		***Company Tracking #:***	*41765-A*

State:	*Arkansas*	***Filing Company:***	*American Medical Security Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*AR AMSLIC*		
Project Name/Number:	*AR Notice of Appeal Rights/41765-A*		

Form Schedule

Lead Form Number: 41059-A

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/26/2012	41059-A	OTH	Notice of Appeal Rights (Non-Grandfathered Plans)	Initial:		41059-A AR Notice of Appeal Rights NGF final w brackets 09 20 12.pdf
2	Approved-Closed 09/26/2012	41765-A	OTH	Notice of Appeal Rights (Grandfathered Plans)	Initial:		41765-A AR Notice of Appeal Rights GF final w brackets 09 20 12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

NOTICE OF APPEAL RIGHTS
Non-Grandfathered Plans

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact us when you:

- Do not understand the reason for denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your insurance contract;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

Internal Review: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [PO Box 13597, Green Bay, WI 54307-3597] within **180 calendar days** of the date you receive your denial. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within **30 calendar days** of receiving your appeal regarding a pre-service claim or within **60 calendar days** of receiving your appeal regarding a post-service claim. If your appeal involves an urgent care claim, the review will be completed as soon as possible, but no longer than within 72 hours of the request.

If your claim was denied on appeal or you do not receive our decision within the allotted **30 or 60 calendar days** of us receiving your appeal, you may be entitled to file a request for external review. You may also be entitled to file a request for external review if we waive the internal review process.

External Review: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational may also be eligible for external review. You can submit a request for external review within **4 months** after receipt of this notice to the External Review Division, Arkansas Insurance Department at [1200 West 3rd Street, Little Rock, AR 72201]. For standard external review, a decision will be made within **45 days** of receiving your request.

If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial at the same time you file a request for, or upon completion of, an expedited internal review. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational and your treating physician certifies in writing that the recommended or requested health care service or

treatment would be significantly less effective if not promptly initiated, you also may be entitled to file a request for an expedited external review of our denial at the same time you file a request for, or upon completion of, an expedited internal review. If applicable, the independent review organization assigned to conduct the expedited external review will determine whether you will be required to complete the expedited internal review prior to proceeding to expedited external review. For appeals involving an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, you may request an expedited external review upon completion of an expedited internal review.

When filing a request for external review, you will be required to authorize the release of your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

For details, please review your insurance contract, contact us, or contact your state insurance department.

NOTICE OF APPEAL RIGHTS
Grandfathered Plans

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact us when you:

- Do not understand the reason for denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your insurance contract;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

Internal Review: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [PO Box 13597, Green Bay, WI 54307-3597] within **180 days** of the date you receive your denial. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within **30 days** of receiving your appeal regarding a pre-service claim or within **60 days** of receiving your appeal regarding a post-service claim. If your appeal involves a medical condition requiring an expedited decision, the review will be handled in an expedited manner.

If your claim was denied on appeal or you do not receive our decision within the allotted **30 or 60 days** of us receiving your appeal, you may be entitled to file a request for external review. You may also be entitled to file a request for external review if we waive the internal review process.

External Review: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational may also be eligible for external review. You can submit a request for external review within **4 months** after receipt of this notice to the External Review Division, Arkansas Insurance Department at [1200 West 3rd Street, Little Rock, AR 72201]. For standard external review, a decision will be made within **45 days** of receiving your request.

If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial at the same time you file a request for, or upon completion of, an expedited internal review. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational and your treating physician certifies in writing that the recommended or requested health care service or

treatment would be significantly less effective if not promptly initiated, you also may be entitled to file a request for an expedited external review of our denial at the same time you file a request for, or upon completion of, an expedited internal review. If applicable, the independent review organization assigned to conduct the expedited external review will determine whether you will be required to complete the expedited internal review prior to proceeding to expedited external review. For appeals involving an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility, you may request an expedited external review upon completion of an expedited internal review.

When filing a request for external review, you will be required to authorize the release of your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

For details, please review your insurance contract, contact us, or contact your state insurance department.

SERFF Tracking #:	*AMMS-128697244*	***State Tracking #:***	***Company Tracking #:*** *41765-A*

State:	*Arkansas*	***Filing Company:***	*American Medical Security Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*AR AMSLIC*		
Project Name/Number:	*AR Notice of Appeal Rights/41765-A*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Bypassed - Item:	Flesch Certification	Approved-Closed	09/26/2012
Bypass Reason:	not applicable		
Comments:			

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved-Closed	09/26/2012
Bypass Reason:	not applicable		
Comments:			

		Item Status:	**Status Date:**
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/26/2012
Bypass Reason:	not applicable - rates are not affected		
Comments:			

		Item Status:	**Status Date:**
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/26/2012
Bypass Reason:	not applicable		
Comments:			

		Item Status:	**Status Date:**
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/26/2012
Comments:			
Attachment(s):			
PPACA Uniform Compliance Summary.pdf			

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
American Medical Security Life Insurance Company	97179	AMMS-128697244		☐ Yes ☑ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: Not applicable to this filing			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: Not applicable to this filing			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: Not applicable to this filing			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☐ **Yes** ☑ No If **no**, please explain
	Explanation: Not applicable to this filing			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: Not applicable to this filing			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☑ No If **no**, please explain.	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: Not applicable to this filing			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: 41059-A			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☑ No If **no,** please explain.
	Explanation: Not applicable to this filing			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: Not applicable to this filing			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☑ No If **no**, please explain.
	Explanation: Not applicable to this filing			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			